FINAL REPORT OF THE

LEGISLATIVE COMMISSION ON MEDICAL

COST CONTAINMENT

NORTH CAROLINA GENERAL ASSEMBLY
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July 17, 1985

The Honorable Robert B. Jordan, III
North Carolina General Assembly
Legislative Office Building
Raleigh, North Carolina 27611

Dear Lieutenant Governor Jordan:

The Legislative Commission on Medical Cost Containment was established by the General Assembly in 1983, and with this report we are completing our work.

Over the past 18 months the members of the Commission have heard from many North Carolina citizens on the problems of medical cost containment. While none of our members believe that the rapid rise in medical costs will be totally solved by the recommendations of this Commission, we do believe that they will contribute to the foundation that has already been laid by the work of previous legislative sessions.

We stand ready to answer any questions that members of the General Assembly may have about our report.

Sincerely,

W. Craig Lawing
James D. Black

LEGISLATIVE COMMISSION ON MEDICAL COST CONTAINMENT
MEMBERSHIP

Representative James B. Black - House Cochairman
Senator W. Craig Lawing - Senate Cochairman

Mr. Carson Bain

Mrs. Jimmie Butts

Mr. William Eller

Mrs. Helen Goldstein

Representative Barney Woodard

Senator Anthony Rand

Dr. Sandra Greene

Mr. Travis Tomlinson, Sr.

Mr. Jack Willis

Dr. Lawrence Cutchins

Mr. Robert F. Burgin (Ex Officio)

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SUMMARY OF COMMISSION ACTIVITIES

The 1983 session of the General Assembly enacted Senate Bill 518, "An Act To Create The Legislative Commission On Medical Cost Containment". The legislation authorized the Commission to study the following issues:

1. The present health care system in North Carolina and the cost trends associated with that system;

2. The cost trends resulting from the problem of the collection of hospital bad debts;

3. The North Carolina Medicaid program and the cost trends associated with that program;

4. The medical cost containment programs established in North Carolina and other states;

5. The composition, funding structure, staffing hearing procedures, public comment procedures and other aspects of the operation of the Health Systems Agencies;

6. The operation of hospital rate review programs;

7. The experience with North Carolina's certificate of need law.

The Commission's meetings were heavily attended by members of the public and representatives of all major provider groups and professional associations. Over 50 persons spoke to the Commission on various topics, and some speakers appeared on several occasions. A partial list of presenters is contained in Appendix A of this report.

The work of the Commission can be divided into two phases. Phase 1 began in December 1983 and continued through March 1984.

Phase I activities consisted of the following:

- An overview of the medical care delivery system in the United States and North Carolina and those factors that contribute to the cost of health care.

- The impact of governmental and private sector reimbursement practices on the cost of health care.

- Utilization patterns in North Carolina hospitals, with particular emphasis on the small rural hospital.

- The financial condition of North Carolina hospitals.
- Defensive medicine and its role in increasing health care costs.
- Nursing home bed moratorium.
- North Carolina's Medicaid program.
- The implementation of Diagnostic Related Groupings (DRG's) in the Medicare program.
- The role of various medical professionals in holding down the cost of care.
- The operation of health planning, certificate of need, and health systems agencies (HSAs) in North Carolina.
- The need for hospital utilization and cost data by government, business, and industry.
- Indigent care in North Carolina and cost shifting to private patients to pay for that care.
- Certificate of need and insurance law changes relating to alcohol and drug rehabilitation program.
- Proposal to finance indigent care in North Carolina through a lottery.

After reviewing these topics, the Commission determined that the focus for the 1984 legislative session would be matters that required immediate action by the General Assembly.

To expedite its work the Commission appointed a subcommittee to deal with issues relating to health planning and certificate of need laws. This subcommittee, chaired by Mr. Carson Bain was very active in 1984 and continued its work in 1985 for the final report to the General Assembly.

RECOMMENDATIONS TO THE 1984 SESSION OF THE GENERAL ASSEMBLY

HB 1613 AN ACT TO PROVIDE TIME TO STUDY THE NEED FOR AND THE
SB 741 PROVIDING OF SERVICES BY HOME HEALTH AGENCIES AS ALTERNATIVE TO INSTITUTIONAL CARE

Findings

Home Health Services are defined in state regulations as a range of services rendered to patients in their homes by a home health agency. Home health agencies must provide skilled nursing care and at least one other therapeutic service to persons in their homes. These other services may include home health aides services; physical therapy; occupational therapy; speech therapy and audiology services; or services of a medical social worker.

Currently there are 96 certified home health agencies in North Carolina.

Recently there has been a trend toward the growth of new home health agencies, but it is not clear whether new programs are needed or expansion of existing agencies.

Recommendations

The findings of the Commission included 1) a concern about the rapid growth of new home health agencies 2) a concern about excess costs as a result a duplication of services 3) need to assess the impact of these changes in home health service.

This moratorium was recommended by Dr. Sarah Morrow, Secretary of the Department of Human Resources.

HB 1585 AN ACT TO END THE MORATORIUM ON NURSING HOME
SB 744 CONSTRUCTION

Findings

In the fall of 1981 the General Assembly placed a moratorium on the construction of new nursing home beds for the following reasons: 1) additional time was needed to develop community alternatives to institutional care; 2) additional time was needed to assess the impact of the Reagan budget cuts on the state's Medicaid program; 3) to force the construction of nursing home beds for which certificate of need had been awarded but no active construction had begun. There were in excess of 1,000 beds in this last category. The language establishing the moratorium said that until all beds for which certificates of need had been awarded were constructed and occupied at 75%, no new certificates of need would be issued.

The Legislative Commission on Medical Cost Containment was informed by the Department of Human Resources that all beds for which certificates of need had been awarded prior to the freeze had been built and were at 75% occupancy, with one exception. This exception was a skilled nursing unit attached to Pender Memorial Hospital in Burgaw. Based on estimates furnished to the Department of Human Resources by the architect it is not likely that the project will be completed and at 75% occupancy prior to the end of 1984.

Recommendation

The Commission felt that in view of the need for additional nursing home beds in North Carolina; the time needed to review and award certificates of need; and the lag time in building new facilities; that it would be best course of action for the General Assembly to lift the moratorium effective July 1, 1984.

HB 1612 AN ACT TO EXTEND THE FREEZE ON THE ISSUANCE OF
SB 740 CERTIFICATE OF NEED FOR NEW INTERMEDIATE CARE FACILITY BEDS FOR THE MENTALLY RETARDED

Findings

The 1983 Session of the General Assembly enacted HB 583 establishing a one-year moratorium on the awarding of certificates of need for intermediate care facilities for the mentally retarded (ICF/MR). The current freeze expires June 30, 1984. ICF/MR beds are a specialized category of nursing home facility in which treatment, education, and rehabilitation services are provided to retarded persons. The reason for this freeze was to give the state, local governments, and the patient advocate groups more time to plan for the residential needs of retarded persons.

Dr. Sarah Morrow, Secretary of the Department of Human Resources, came before the Medical Cost Containment Commission and asked that the moratorium be extended for six months, until January 1, 1985.

Recommendation

The Commission believes that extending the freeze for six months would allow for more public input and planning on the need for additional ICF/MR beds.

HB 1586 AN ACT TO MAKE FINAL AGENCY DECISIONS ON
SB 742 CERTIFICATE OF NEED APPEALABLE TO THE NORTH CAROLINA COURT OF APPEALS

Findings

Under current North Carolina law the final decision by the Department of Human Resources to award a certificate of need may be appealed to Superior Court, and from there to the Court of Appeals, and the North Carolina Supreme Court. There is no federal requirement that cases go to all three levels of the North Carolina court system.

The Commission found that because of the extremely competitive nature of the certificate of need process many of the final decisions by the department were being appealed to the courts. If a plaintiff chose to exercise all rights of appeal a decision on vitally needed services might be prolonged for many years.

Because of the extreme complexity of these cases and the very lengthy records that are usually involved, they place a great burden on the Superior Court.

Recommendation

Following a final agency decision, an appeal of any certificate of need case should go directly to the North Carolina Court of Appeals.

SB 744 TECHNICAL AMENDMENTS TO THE CERTIFICATE OF NEED LAW

Findings

The Commission found that a number of technical changes were needed in the certificate of need law to better align regulatory practices with existing laws.

Recommendation

The Commission submitted all of these technical changes as one omnibus bill to the 1984 session of the General Assembly.

Senate Bill 775 AN ACT TO INCREASE THE LIMIT ON MAJOR MEDICAL EQUIPMENT REQUIRING A CERTIFICATE OF NEED AND MAKE IT APPLICABLE TO PHYSICIANS IN ADDITION TO HEALTH CARE FACILITIES

Findings

The current law requires a certificate of need if a hospital or other institution acquires a piece of medical equipment. Major medical equipment in physicians' offices is now covered only if the equipment will be used to serve in patients of hospitals.

During its deliberations the Commission reviewed in detail the current Certificate of Need Law. The consensus was that hospitals and physicians should be treated equally.

Under the current law the local health system agencies and the State may decide that there is a need for only one CAT scanner or Nuclear Magnetic Resonance machines in a given area. Decisions on need are based on the most efficient use of equipment, and getting the most out of dollars expended. Nothing in current law, however, would prevent private groups of physicians from purchasing the same equipment and seeing patients on an outpatient basis.

The results of these purchases by private groups would likely be the following 1) greater overall expenditures for medical care within the county 2) possibly underutilized equipment in both hospitals and physicians' offices because of excess capacity.

Recommendation

The Commission recommended to the 1984 General Assembly that major medical equipment be covered under the certificate of need law in both hospitals and outpatient settings.

FUNDING FOR HEALTH SYSTEM AGENCIES (HSA)

The Commission recommended that the General Assembly contribute State funds to the Health System Agencies. This item was funded in the main appropriations bill.

In the section of this report dealing with recommendations to the 1985 General Assembly, the Commission has spoken further to this issue.

ACTIONS BY THE 1984 GENERAL ASSEMBLY

All of the recommendations to the 1984 General Assembly were enacted with the exception of the expansion of the certificate of need law to cover major medical equipment in an outpatient setting.

SUMMARY OF 1984-85
COMMISSION ON ACTIVITIES

The Commission activities in the 1984-85 period were focused in three areas: 1) the collection of medical data 2) indigent care 3) health education and preventive health care. The Commission co-chairmen appointed Mr. Robert Burgin, President of Memorial Mission Hospital, as an Ad Hoc member of the Commission. Mr. Burgin had just completed work with a special task force in Buncombe County that had studied the problems of indigent care.

MEDICAL DATA

After hearing about the need for uniform hospital data for purchasers of health services, health care providers, state agencies, and insurers the co-chairmen appointed a special Ad Hoc Committee to review this issue. This Committee was composed of commission members, representatives from business and industry, the North Carolina Hospital Association and the North Carolina Medical Society. Appendix B contains a list of the members of this committee. This committee met for several months and a copy of its report and recommendation is contained in Appendix C.

UNCOMPENSATED CARE

In the past two years nationwide attention has been focused on the growing problem of uncompensated indigent care, especially in hospitals. The Commission spent a number of meetings hearing testimony on the extent of this problem in North Carolina. A major study conducted by the Center for Health Policy Research and Education is now underway in North Carolina, and the preliminary results were presented to the Commission in January 1985. A copy of this report is contained in Appendix D.

HEALTH EDUCATION AND PREVENTIVE HEALTH CARE

In recent years attention has been focused in both business and government on the effectiveness of preventive health programs. A subcommittee of the Commission dealt with these issues, particularly with regard to health education programs in the public schools. A copy of this subcommittee's report and a membership list is contained in Appendix E and F.

RECOMMENDATIONS TO THE 1985 GENERAL ASSEMBLY

MEDICAL DATA AND HOSPITAL RATE REVIEW

1. Hospital rate review agencies now operate in a number of states, and they appear to contribute to a reduction in the rate of increase in hospital costs in these states.

2. The Commission also found that for a hospital rate review program to be successful it must cover all payors, governmental and private alike. At this time, however, it appears that the federal government may not allow additional waivers for a state to assume responsibility for Medicare rates.

3. During its review the Commission found that the growth of alternative health delivery plans in North Carolina accelerated within the past 24 months. The full impact of alternatives such as health maintenance organizations, preferred provider plans, and preadmission certification programs on hospital admissions and costs may not be felt for another 12 to 18 months.

4. The Commission also found that both the public and private sector have a great need for timely and accurate information on the cost and utilization of health care services. The greatest need for this kind of information is in the area of hospital utilization. Research presented to the Commission shows wide variations in rates of hospitalization for the same procedures in North Carolina communities. These variations in patterns care have contributed to the rapid increase in the cost of health care.

Recommendations

The Commission recommends that the General Assembly establish a system to monitor the cost of health care costs in North Carolina with particular emphasis on hospitals, but that no action should be taken at this time to create a hospital rate review authority in North Carolina.

As an alternative to rate review, the Commission recommends the creation of a statewide medical database to be made available to all purchasers of health services, health care providers, state agencies, and insurers on the cost and utilization of medical services in North Carolina. The database would begin with a record of each acute inpatient hospital admission in North Carolina, and could be expanded to other services in the future with approval of the General Assembly. A copy of the recommended bill is found in Appendix C.

Careful monitoring of hospital costs and utilization should occur, and if costs were again to accelerate at a rapid rate consideration should be given to alternatives, such as hospital rate review, to restrain these increases.

STATE TECHNICAL ASSISTANCE TO HOSPITALS

Findings

Major changes are occurring in the hospital industry during the 1980's as a result of:

- Changing medical referral patterns within communities.
- Governmental initiatives that affect Medicare and Medicaid reimbursements. e.g. Medicare payments based on Diagnostic Related Grouping (DRG's) and reductions in federal Medicaid appropriations.
- Declining inpatient utilization due to stronger utilization controls in the public and private sector.
- The cost of providing services to indigent patients.

The impact of these changes are being especially felt in public hospitals of less than 200 beds. Because of these changes in patterns of care and reimbursement county governments are becoming increasingly involved in the problems of local hospitals.

Both hospitals and commissioners in recent months have found the need to request assistance from the State, but no single agency within the executive branch has been designated to coordinate these requests.

Recommendation

The Commission recommends that the Governor designate an existing agency within the Department of Human Resources to provide technical assistance on hospital matters to county governments or hospitals when such assistance is requested by the hospital trustees or the county commissioners.

Since the subcommitte on Health Planning made its initial recommendation on this issue, Governor Martin has designated the Office of Rural Health Services of the Department of Human Resources as the lead agency for the Community Hospital Technical Assistance Program. Assistance under this program will be provided to county-owned or private non-profit hospitals that request assistance from the state.

HEALTH SYSTEM AGENCIES FINDING

The Commission finds that there is a need for a strong local role in the health planning and certificate of need process. Health system agencies provide a way for both consumers and providers to come together to help determine local health care needs. Without this advice the state would be in the difficult position of attempting to make all health planning decisions from Raleigh.

Recommendation

The Commission recommends that the state retain the present Health System Agency System, and that these local agencies continue in an advisory role on health planning and certificate of need matters.

The Commission also recommends, as it did in 1983, that the General Assembly continue to appropriate $360,000 in each year of the 1985-87 biennium as a grant to these agencies.

HEALTH EDUCATION AND PREVENTIVE HEALTH CARE

Findings

House bill 540, entitled "An Act To Establish A Statewide School Health Education Program Over A Ten-Year Period," was enacted by the General Assembly in 1978. The Act (G.S. 115C-81(e), a copy of which is attached, authorized the appropriation of funds for employing health education coordinators, with the goal of one coordinator per local education agency. Additionally, the Act called for one additional consultant's position in Department for Health Education; and the creation of a statewide health education advisory council to "provide citizens input...." The legislation also called for the development of a health curriculum for grades K-9. In 1979, the General Assembly passed HB 974 which allocated funds for eight (8) additional health education coordinators. In 1984, funds were appropriated for the employment of 16 additional health coordinators.

HB 276 introduced in the 1985 Legislative Session calls for funding of 32 additional positions.

Recommendations

1. The Commission recommends that the General Assembly continue the expansion of the health education coordinator program as originally proposed in HB 540. This would continue to expand the program until there was a health education coordinator in all school districts.

2. The commission recommends that the health education coordinator program be a part of the proposed Basic Education Plan (BEP).

GENERAL ASSEMBLY - MEDICAL COST CONTAINMENT

Findings

The General Assembly has established two Commissions on Medical Cost Containment since 1977. Both of these have made numerous recommendations to the General Assembly, but the lack of an ongoing effort in the medical cost containment area makes it difficult for the General Assembly to formulate policies that may need to be enacted over several bienniums.

Recommendations

The Commission recommends that the General Assembly establish a standing Commission similar to those that now exist in the mental health and special education fields to work on matters dealing with medical cost containment, and other issues that the General Assembly may see fit to assign. Such issues might include the promotion of cost containment in the state employees health insurance plan.

INDIGENT CARE AND MEDICAID USE OF DIAGNOSTIC RELATED GROUPINGS

Findings

The Commission heard testimony from hosptials, physicians, and the business community about the problems of indigent care and the cost shifting that must occur to pay for that care. As a part of this review the Commission examined the Diagnostic Related Grouping (DRG) reimbursement system as it is now being implemented in the Medicare program. The Commission found that while the new payment system is helping to reduce lengths of stay in hospitals, it still appears too early to assess the impact on the hospital system in North Carolina. Thus it appears premature to adopt such as payment system in the Medicaid program.

A major study is now underway in North Carolina, by the Center for Health Policy Research and Education at Duke University, that examines the health care costs of both the uninsured and the underinsured in North Carolina. The report will also examine the options that are available to government and business for dealing with the problem. The results of this study are not yet available, and the Commission is not prepared at this time to make recommendations on legislative actions on uncompensated care.

Recommendations

Indigent Care

The General Assembly should continue to study the issue of indigent care and the options that are available to address the problem. Such a study might be best handled by a special study commission devoted solely to this task.

Use of Diagnostic Related Groupings for Medicaid Reimbursement

The Commission recommends that further study occur by both the Department of Human Resoruces and the General Assembly before a decision is made to implement a DRG Type of program in the North Carolina's Medicaid program.

APPENDIX A - LIST OF PERSONS APPEARING BEFORE THE COMMISSION

PERSONS APPEARING BEFORE THE COMMISSION

Ms. Barbara Matula	Director, Division of Medical Assistance, Department of Human Resources
Mr. Ernest Messer	Director, Division of Aging, Department of Human Resources
Mr. Glenn Wilson	Chairman of the Department of Social and Administrative Medicine, UNC School of Medicine
Dr. Deborah Freund	Professor Health Policy Administration, UNC Chapel Hill
Dr. Jack Hughes	President (1983) N. C. Medical Society
Mr. Pete Roy	Director, Management Services N. C. Hospital Association
Mr. Dan Mosca	President (1983) N. C. Health Care Facilities Association
Mr. James Bernstein	Director, Office of Rural Health Services
Mr. Calvin Michaels	Director of Personnel, Burlington Industries, Inc.
Mr. Jan Rivenbark	Director, of Compensation and Benefits, Hanes Group
Mr. Charles N. Burger	Director, Uniform Business/Medical Coalition, Hickory, N. C.
Mr. William D. Fullerton	Adjunct Professor, Department of Social and Administrative Medicine, UNC - Chapel Hill
Dr. Stuart Fountain	Member of the Board of Trustees of the N. C. Dental Society
Ms. Judith Seamon	President, N. C. Nurses Association
Ms. Linda Cothrell	President, N. C. Nurses Association of Nurse Anesthetists

Dr. Duncan Yaggy	Chief Planning Officer, Duke University Medical Center
Dr. Barbara Kramer	Director State Health Planning, Department of Human Resources
Mr. Gary Vaughan	Director, Certificate of Need, Department of Human Resources
Mr. George Stockbridge	Executive Director Capital Health Systems Agency
Senator Marvin Ward	Winston-Salem, N. C.
Dr. Sarah Morrow	Secretary, Department of Human Resources
Mr. Bill Shenton	Attorney at Law
Dr. William Weissert	Professor of Health Policy and Administration, UNC - Chapel Hill
Mr. Noah Huffstetler	Attorney at Law
Mr. Jack Pleasant	N. C. Legal Services Resources Center
Mr. Charles Moeller	Director, Western Health Systems Agency
Dr. Edward McKensensie	Salisbury, N. C.
Mr. Bob Burgin	President, Memorial Mission Hospital, Asheville
Mr. Henry Nurkin	President, Charlotte Memorial Hospital and Medical Center
Mr. Bryon I. Bullard	President, Charlotte Presbyterian Hospital
Mr. George Stiles	Executive Director, Mecklenburg County Health Care Cost Management Council
Dr. Robert Payne	President, Mecklenburg County Medical Society
Mr. Ken Brown	Preferred Care of N. C.
Mr. Melvin Whitley	Carolina Action

Mr. Randy Desonia	Intergovernmental Health Policy Project - George Washington University Mecklenburg Council of Senior Citizens
Ms. Inez Myles	N. C. Senior Citizens Federation
Dr. Regionald Carter	Duke University
Ms. Janet Campbell	
Dr. Patricia Danzon	Duke University
Mr. Steve Morrisette	N. C. Hospital Association
Mr. Ron Aycock	N. C. County Commissioners Association
Ms. Donna Montgomery	N. C. Alliance for Social Security Disability Recipients

APPENDIX B - AD HOC COMMITTEE ON HOSPITAL DATA

AD HOC COMMITTEE ON HOSPITAL DATA

Dr. Sandra Greene - Chairman

Mr. Pete Burger

Dr. John Foust

Mr. Eugene Hill

Mr. Calvin Michaels

Senator Tony Rand

Mr. Travis Shamel

Mr. Jack Willis

Mr. Glenn Wilson

Dr. Duncan Yaggy

APPENDIX C - REPORT OF THE HOSPITAL DATA COMMITTEE

DRAFT

Attachment 1

PROPOSAL FOR A STATEWIDE MEDICAL DATABASE

November 19, 1984

Purpose

The purpose of a statewide medical database is to make available to purchasers of health services, health care providers, State agencies, and insurers, information on the cost and utilization of medical services in North Carolina.

Scope

Initially, the database is to contain a record of each acute inpatient hospital admission in North Carolina. This would include admissions to non-federal acute care hospitals for all payors: Medicare, Medicaid, Blue Cross and Blue Shield of North Carolina (BCBSNC), commercial insurance companies, self-pay and nonpay. At a later stage of development, other categories of service may be added: emergency room use, long-term care episodes, nursing home care, etc.

The database will be continually updated on a quarterly or semiannual basis. The data will be based on dates of services such that a database for 1985 would consist of records for all patients discharged during 1985.

Governance

A permanent nine member commission will be established to direct the Statewide Medical Database. The composition would be:

3 Employers (one with 500+ employees, one with 100 - 500 employees and one with less than 100 employees, to be chosen after consultation with the North Carolina Citizens for Business and Industry and other employers)

1 Hospital administrator, as recommended by the North Carolina Hospital Association

1 Physician, as recommended by the North Carolina Medical Society

1 Representative of State government at large

1 Commercial insurance company representative from a company licensed and active in the health insurance industry in North Carolina

1 Blue Cross and Blue Shield of North Carolina representative

Chairman, Board of Trustees, Teachers and State Employees Comprehensive Major Medical Plan

North Carolina Insurance Commissioner, ex officio and non-voting

Secretary, North Carolina Department of Human Resources, ex officio and nonvoting

The employer from a business with 500 or more employees, the hospital administrator and the representative of a commerical insurance company will be appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives. The employer from a business with 100 to 500 employees, the physician representative and the BCBSNC representative shall be appointed by the President pro tem of the Senate. The employer from a business with less than 100 employees, the representative of State government at large and the Chairman of the Board of Trustees of the Teachers and State Employees Comprehensive Major Medical Plan shall be appointed by the Governor.

The Chairman will be one of the nine members, as elected by the members. Commission members will serve staggered three-year terms with three expiring each year. An individual may serve a maximum of two full terms.

Agency to House the Commission

The agency designated to house the Commission for housekeeping purposes is the North Carolina Department of Administration.

Data Processor

The Commission will contract with a data processor to carry out the project.

The function of the data processor is to collect the data from hospitals and third party carriers, to build and maintain the databases, and to analyze the information. This will be done under the governance of the Commission. The data processor will maintain a staff to develop annual utilization and cost reports. The staff will also be available to analyze more specific information at the request of an employer, an HSA, a State agency, or other interested party. Guidelines for reports and special requests would be developed by the Commission.

Process

The data are to be obtained as a byproduct of the UB-82 claim form.* It is the responsibility of the Commission to determine the most cost effective method of obtaining the data. Initially, it is likely that this will necessitate some data submission by insurance carriers, as well as some submission from the hospitals. For the four largest groups of insured in North Carolina (BCBSNC subscribers, Medicare, Medicaid and State employees), the carriers will provide tapes of the UB-82 claim forms. For patients not included in one of the above four groups, the Commission will decide on an annual basis the appropriate method of collection. The primary method would be to obtain a copy of the claim from the hospital either on paper or tape. However, for carriers that account for substantial numbers of hospital discharges, the Commission may later request that the North Carolina Insurance Department require a tape of those discharges from the carrier. A determination of which carriers would be affected would be made prior to each new year of data collection. Then hospitals and carriers

*UB-82 is the new uniform hospital billing form used in North Carolina by all providers since October 1, 1984.

would be notified by the North Carolina Department of Insurance. The State will mandate the provision of this information from the hospitals and carriers to the Commission.

Data Elements

The UB-82 claim form contains more information than is needed for this project. Therefore, only selected data elements would be extracted.

There are 28 data elements to be included for each hospital discharge, comprising about 200 characters (see attached list). These data elements include information on the patient, the hospital, the physicians providing care during the admission, the nature of the admission, surgical procedures performed, and charge information by ancillary category.

Confidentiality

To insure confidentiality of individual patient records, patient names are to be omitted from the database.

Guidelines on the accessibility and dissemination of the data will be developed by the Commission.

Cost

A preliminary estimate indicates that the annual cost of a statewide hospital data base is about $400,000 - $450,000. This includes funds for the following activities:

- Qualified staff to oversee the development and maintenance of the database.
- Reimbursing carriers that supply tapes of the UB-82 claims.
- Reimbursing hospitals for the expense of providing the data to the data processor.

- Data entry for the [illegible] percent of the claims submitted in paper form from the hospitals.
- Data processing for building, updating and maintaining the database.
- Compiling and distributing an annual report of cost and utilization data.
- Technical staff available to respond to specific requests for data.
- Board members' travel expenses.

(Note: For the first year, the cost will be substantially less than the $400,000 - $450,000, due to the time involved in start up.)

Funding

The Commission will be funded initially with 100 percent State funds. Subsequently, partial support will be sought through corporate grants, foundation grants and user fees.

H.E.R.
8/29/84

DRAFT

STATEWIDE HOSPITAL DATABASE

		No. of Characters	UB-82 Manual Page
1.	Patient control number	12	17
2.	Date of birth	6	30
3.	Sex	1	31
4.	Zip code of patient's residence	5	29
5.	Employer name	24	130
6.	Hospital identifier (Federal tax number)	10	24
7.	Payer identification	2	105
8.	Source of admission	1	36
9.	Admission date	6	33
10.	Discharge date (statement covers period)	6	41
11.	Patient status	2	40
12.	Principal diagnosis	5	134
13.	Other diagnoses (4)	20	135
14.	Principal procedure	5	138
15.	Other procedures (2)	10	139
16.	Attending physician ID	6	144
17.	Other physician ID	6	145
18.	Total hospital charge	6	72
19.	Room and board charges	6	72-77
20.	Operating room charge	6	83
21.	Anesthesia charge	6	84
22.	Pharmacy charge	6	79
23.	Radiology charge	6	82-83
24.	Laboratory charge	6	81
25.	Medical surgical supplies & devices charge	6	80
26.	Physical therapy charge	6	85
27.	Respiratory services charge	6	85
28.	Incremental nursing charge	6	78
		197	

APPENDIX D - PRELIMINARY REPORT ON INDIGENT CARE IN NORTH CAROLINA

DRAFT

Presentation to the

Legislative Commission on
Medical Cost Containment

Duke University
Center for Health Policy
Research & Education

NOTE: All figures contained in this briefing are preliminary estimates and should not be disseminated further without permission from the Center for Health Policy Research and Education.

ESTIMATED NUMBER OF PERSONS
WITHOUT PUBLIC OR PRIVATE HEALTH INSURANCE
NORTH CAROLINA, 1984

INCOME LEVEL	TOTAL 1984 POPULATION	AVERAGE DAILY UNINSURED			PERSONS ALWAYS UNINSURED
		Rate	Total Persons	Distri-bution	
Very Poor	774,742	18.1%	140,057	19 %	95,945
Poor	409,609	16.5	67,743	9	46,170
Near Poor	954,863	17.7	168,766	23	115,565
All Others	4,059,099	8.7	351,192	49	265,630
TOTAL	6,198,313	11.7%	727,758	100%	523,310

es: 1976 Survey of Income and Education (North Carolina data).
1977 National Medical Care Expenditure Survey.
1981 North Carolina Citizens Survey (Fall).
1982 North Carolina Citizens Survey (Fall).
1983 Colorado Health Survey.

ESTIMATED DISTRIBUTION OF
AVERAGE DAILY UNINSURED PERSONS IN
NORTH CAROLINA, 1984

AGE	AVERAGE DAILY UNINSURED	VERY POOR (Under 75%)	POOR (76-100%)	NEAR POOR (101-150%)	NOT POOR (Over 150%)	TOTAL
Under 6	58,424	1.9 %	0.9 %	2.3 %	2.9 %	8.0 %
6 to 17	168,605	5.1	2.4	5.8	9.9	23.2
18 to 64	483,174	12.1	5.9	15.0	33.4	66.4
65 and up	17,555	0.1	0.1	0.2	2.0	2.4
TOTAL	727,758	19.2 %	9.3 %	23.2 %	48.3 %	100.0 %

OURCES: Estimated based on data from the following sources:
1976 Survey of Income and Education (North Carolina data)
1977 National Medical Care Expenditure Survey
1981 North Carolina Citizens Survey (Fall)
1982 North Carolina Citizens Survey (Fall)
1983 Colorado Health Survey

EDUCATION, EMPLOYMENT AND INCOME CHARACTERISTICS OF ADULTS 18 TO 64 IN NORTH CAROLINA, BY INSURANCE STATUS

CHARACTERISTIC	UNINSURED	PRIVATE COVERAGE	MEDICAID
SAMPLE SIZE	501	3,999	343
EDUCATION*			
0 to 8 Years	21	9	27
9 to 11	26	15	27
12	37	41	31
13 to 15	12	18	9
16 and over	3	17	3
EMPLOYMENT STATUS*			
Full-time Worker	40	74	21
Part-time Worker	13	6	5
Unemployed	15	2	6
Not Seeking Work	32	17	67
New Job (under 1 year)	21	13	8
FAMILY INCOME			
$0 to 9,999	36	8	53
10,000 to 14,999	24	20	14
15,000 to 19,999	10	17	6
20,000 to 29,999	8	22	4
30,000 and over	3	23	6
PUBLIC SOURCES OF INCOME**			
Unemployment Compensation	23	15	6
Veterans Payments	6	5	9
Social Security	22	12	33
Workmens' Compensation	5	4	2
Welfare (AFDC or SSI)	21	3	64
At least one of above	56	31	86

North Carolina Citizens Surveys, 1979 to 1983.

All figures shown are for adults 18 through 64. Percentages are based on the average for all years in which a particular question was asked. All percentages are based on weighted survey responses unless otherwise shown.

on unweighted responses.

ast part of the family's income came from the sources shown.

DEMOGRAPHIC CHARACTERISTICS OF ADULTS 18 TO 64
IN NORTH CAROLINA, BY INSURANCE STATUS

CHARACTERISTIC	UNINSURED	PRIVATE COVERAGE	MEDICAID
SAMPLE SIZE	501	3,999	343
AGE*			
18 to 29	39 %	27 %	31 %
30 to 49	39	48	34
50 to 64	22	24	35
SEX (Percent Female)*	57	54	74
RACE			
White	56	78	45
Black	41	20	49
HOUSEHOLD SIZE			
1 member	6	6	10
2 members	18	25	21
3 or more	76	69	70
NUMBER OF CHILDREN UNDER 18**	1.32	1.01	1.74
COMMUNITY SIZE			
Under 2,500	65	62	53
2,500 to 9,999	8	7	6
10,000 to 49,999	11	13	14
50,000 and over	15	17	25
REGION			
Mountain	17	14	14
Piedmont	42	58	47
Coastal Plain	29	20	29
Coast	12	8	10

: North Carolina Citizens Surveys, 1979 to 1983.

: All figures shown are for adults 18 through 64. Percentages are based on the average for all years in which a particular question was asked. All percentages are based on weighted survey responses unless otherwise shown.

gures shown are based on unweighted responses.

gures shown are based on 1,070 uninsured respondents, 7,097 respondents with ivate insurance and 477 with Medicaid.

TRENDS IN LACK OF HEALTH INSURANCE COVERAGE AMONG ADULTS IN NORTH CAROLINA, 1979 to 1984

INSURANCE STATUS	1981	1982	1983
SAMPLE SIZE	1,267	1,406	1,465
Uninsured	10.6	9.5	9.9
Private Coverage	61.8	63.3	68.1
Medicare	16.8	20.0	14.0
Medicaid	4.9	3.9	3.8
Other*	6.0	3.4	4.3
TOTAL	100.0%	100.0%	100.0%

E: North Carolina Citizens Surveys, 1979 to 1983.

E: All figures shown are for adults age 18 and over. Percentages are based on weighted survey results and may not add to 100 due to rounding.

ncludes CHAMPUS, coverage by health maintenance organizations, etc.

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Fig. 1

PUBLICLY FUNDED MEDICAL SERVICES
PROGRAMS IN NORTH CAROLINA
WHICH SERVE UNINSURED POOR PERSONS

CATEGORICAL ENTITLEMENTS
VA Health Services
Migrant Health
Refugee Health
Indian Health

PRIMARY CARE CENTERS
Rural Health Centers
Federal Community Health Centers (CHCs)

MATERNAL & CHILD HEALTH
Maternal Health
Family Planning
High Risk Maternity
Perinatal
Delivery Fund
Title XX Sterilizations
State Abortion Fund
Child Health
Immunization
School Health
Dental Health

ADULT HEALTH
Adult Primary Care
Other Adult Health
Cancer Control
Kidney Disease
TB Control
VD Control

GENERAL HEALTH
Health Aid Counties
Home Health
Medical Eye Care
Emergency Medical

DEVELOPMENTAL HEALTH
Medical Vocational Rehabilitation
Genetic Health
Developmental Evaluation Centers
Crippled Children
Lenox Baker Hospital

MENTAL HEALTH
Mental Health Centers
Alcohol Rehabilitation Centers
State Mental Hospitals

Fig. 3

TARGETING OF PUBLICLY FUNDED MEDICAL SERVICES PROGRAMS
ON UNINSURED POOR PERSONS,
STATE FY1984

ATEGORY	TOTAL FY84 EXPENDITURES (thousands)	ESTIMATED DISTRIBUTION OF EXPENDITURES				
		Persons Below Poverty Level			Persons Above Poverty	TOTAL PUBLIC EXPENDITURES ON UNINSURED POOR
		Uninsured	Medicaid	Other		
N BASELINE*		3.4 %	4.4 %	11.3 %	80.9 %	
AL ENTITLEMENTS	$ 141,065.7	7.5	3.5	26.9	62.1	$ 10,557.6
ARE CENTERS	24,276.6	7.9	7.3	25.3	59.6	1,883.9
& CHILD HEALTH	33,844.6	46.6	9.7	24.5	19.2	15,786.6
LTH	8,610.2	24.3	3.1	23.5	49.1	2,094.2
EALTH	112,486.3	5.2	6.1	17.0	71.7	5,821.6
NTAL HEALTH	34,519.3	29.1	7.6	44.2	19.1	10,057.0
ALTH	198,173.2	12.1	4.9	32.4	50.6	24,026.3
AMS	$ 552,976.6	12.7 %	5.3 %	27.7 %	54.3 %	$ 70,227.2

ion baseline shows the distribution of the general population in North Carolina.

ESTIMATED PER CAPITA EXPENDITURES
FOR MEDICAL SERVICES TO UNINSURED POOR PERSONS
THROUGH PUBLIC MEDICAL CARE PROGRAMS,
NORTH CAROLINA, FY84

ROGRAM CATEGORY	TOTAL FY84 EXPENDITURES (thousands)	PERCENT DISTRIBUTION	EXPENDITURES PER CAPITA UNINSURED POOR PERSON
ategorical Entitlements	$ 10,588.6	15.1 %	$ 51
rimary Care Clinics	1,883.9	2.7	9
aternal & Child Health	15,786.6	22.4	76
dult Health	2,094.2	3.0	10
...eral Health	5,821.6	8.3	28
evelopmental Health	10,057.0	14.3	48
ntal Health	24,026.3	34.2	116
TAL	$ 70,227.2	100.0	$ 338

TE: Expenditures per capita were obtained by dividing total expenditures on uninsured poor by the estimated 207,800 poor persons who are uninsured on an average day.

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ESTIMATED EXPENDITURES ON PUBLICLY FUNDED MEDICAL CARE FOR UNINSURED POOR PERSONS, BY REVENUE SOURCE
STATE FY1984

PROGRAM	UNINSURED POOR PERCENT OF PROGRAM OUTLAYS	TOTAL FY84 OUTLAYS ON UNINSURED POOR	SOURCE OF REVENUE		
			Federal	State	Local
CATEGORICAL ENTITLEMENTS	7.5 %	$ 10,588.6	97 %	3 %	0 %
PRIMARY CARE CENTERS	7.9	1,883.9	81	19	0
MATERNAL & CHILD HEALTH	46.6	15,786.6	37	54	9
ADULT HEALTH	24.3	2,094.2	4	95	1
GENERAL HEALTH	5.2	5,821.6	1	48	51
DEVELOPMENTAL HEALTH	29.1	10,057.0	71	28	1
MENTAL HEALTH	24.7	24,026.3	7	78	15
ALL PROGRAMS	12.7 %	$ 70,227.2	38 %	50 %	12 %

Table 8. Deductions from Gross Revenues

North Carolina Community Hospitals (1982)

Ownership Type	Contractual Adjustments	Bad Debt	Charity	Other	Total[a]
Public (28)					
$(thousands)	44,616	27,092	19,337	1,265	91,940
% of Deductions[b]	50.2	42.4	6.8	1.2	100
% of Gross Revenues[b]	9.6	6.9	1.3	0.2	17.8
Non-Profit (87)					
$(thousands)	153,495	101,094	23,308	21,195	299,090
% of Deductions[b]	56.7	32.6	7.7	3.1	100
% of Gross Revenues[b]	10.2	5.8	1.3	0.5	17.8
For-Profit (15)					
$(thousands)	15,896	3,645	397	1,076	21,014
% of Deductions[b]	65.6	24.0	2.2	8.2	100
% of Gross Revenues[b]	9.5	2.6	0.3	0.7	13.0
Total (130)					
$(thousands)	214,006	131,831	43,042	23,536	412,044
% of Deductions[b]	56.3	33.7	6.9	3.3	100
% of Gross Revenues[b]	10.0	5.7	1.2	0.4	17.3

[a]Sum of columns may differ from Total due to reporting error.

[b]Unweighted mean across hospitals.

Table 10. Net Revenues and Costs, by Patient Category

North Carolina Community Hospitals (1982)

Ownership	Medicare	Medicaid	Blue Cross	Commercial	Self Pay	Total[a]
Public (28)						
Costs[b] ($000)	151,596	44,465	67,926	108,080	46,242	449,941
%[b]	39.1	10.8	15.6	20.0	10.8	100
Surplus (-)[c]	2,430	(2,364)	7,696	7,852	(12,315)	1,197
% Reimb.[d]	96.2	95.6	112.2	105.1	82.8	98.9
Non-Profit (87)						
Costs[b] ($000)	509,279	98,832	249,156	348,507	127,142	1,400,000
%[b]	40.6	7.6	16.0	23.4	9.3	100
Surplus (-)[c]	(11,074)	(5,747)	31,423	54,152	(25,090)	50,778
% Reimb.[d]	96.7	92.8	112.6	113.7	80.4	101.7
For-Profit (15)						
Costs[b] ($000)	49,120	7,299	15,819	35,817	9,399	123,058
%[b]	39.8	7.3	11.3	29.1	8.8	100
Surplus (-)[c]	(4,260)	(1,105)	295	2,186	(877)	(399)
% Reimb.[d]	91.5	86.1	101.5	103.6	89.4	100.0
Total (130)						
Costs[b] ($000)	709,995	150,595	332,902	492,404	182,782	1,972,567
%[b]	40.2	8.2	15.4	23.3	9.6	100
Surplus (-)[c]	(12,905)	(9,216)	39,414	64,189	(38,282)	50,576
% Reimb.[d]	96.0	92.6	111.4	110.7	82.0	100.9

[a]Columns do not sum to Total, due to Other patients, not reported here.

[b]Unweighted mean.

[c]Net Patient Revenue-(Total Expenses-Other Operating Revenue).

[d]Net Patient Revenue/(Total Expenses-Other Operating Revenue), unweighted mean.

Table 3.5 DISTRIBUTION OF CHARITY AND BAD DEBT, BY OWNERSHIP, SIZE AND TEACHING STATUS
NORTH CAROLINA COMMUNITY HOSPITALS

e of pital		Number of Hospitals	Beds (%)	Revenue Deductions (Percent) Charity	Bad Debt	Contractual Adjustments	Total
ership	Beds						
lic	< 100	14	3.8	0.9	3.6	3.1	2.9
	100-300	8	6.3	3.4	5.6	5.7	5.0
	> 300	6	13.7	43.0	11.7	12.0	14.8
-profit	< 100	29	7.5	3.2	5.6	5.6	5.1
	100-300	40	27.3	15.8	25.6	28.5	25.1
	> 300	18	35.0	32.7	44.9	37.1	41.6
-profit	< 100	7	1.9	0.2	0.8	1.4	1.1
	100-300	8	4.6	0.8	2.2	6.6	4.4
l		130	100.0	100.0	100.0	100.0	100.0
rship	Teaching Status						
ic	no teaching	24	13.4	4.3	11.1	9.8	9.1
	minor teaching	2	4.4	3.0	3.0	3.4	3.1
	major teaching	2	5.9	40.0	6.9	7.5	10.6
profit	no teaching	77	48.2	24.5	41.6	48.3	41.6
	minor teaching	6	10.9	17.8	13.9	12.7	13.3
	major teaching	4	10.7	9.5	20.6	10.3	17.0
profit	no teaching	14	6.4	1.0	3.0	8.0	5.4
	minor teaching	1	0.1	0.0	0.0	0.0	0.0
l		130	100.0	100.0	100.0	100.0	100.0

Table 3.6 DISTRIBUTION OF SELF PAY AND MEDICAID PATIENTS, BY OWNERSHIP, SIZE AND TEACHING STATUS
NORTH CAROLINA COMMUNITY HOSPITALS

Type of Hospital		Number of Hospitals	Total Expenses	Self Pay Expenses	Self Pay Deficit	Medicaid Expenses	Medicaid Deficit
Ownership	Beds						
Public	< 100	14	2.7	2.6	1.6	3.2	3.3
	100-300	8	4.5	5.5	6.2	3.4	4.3
	> 300	6	15.7	17.2	23.3	23.0	17.9
Non-profit	< 100	29	5.0	4.7	3.4	4.9	5.4
	100-300	40	22.1	22.1	25.1	19.3	19.6
	> 300	18	43.9	42.7	36.9	41.4	40.3
For-profit	< 100	7	1.4	1.6	0.2	1.5	2.4
	100-300	8	4.9	3.6	3.2	3.3	6.9
otal		130	100.0	100.0	100.0	100.0	100.0
Ownership	Teaching Status						
ublic	no teaching	24	9.0	10.7	8.2	9.5	14.0
	minor teaching	2	4.0	2.9	.	3.1	.
	major teaching	2	9.8	11.7	22.9	16.9	11.5
on-profit	no teaching	77	39.8	37.6	30.6	31.1	29.8
	minor teaching	6	12.5	14.3	19.2	12.0	13.3
	major teaching	4	18.7	17.7	15.8	23.0	22.2
or-profit	no teaching	14	6.1	5.0	3.3	4.6	8.7
	minor teaching	1	0.1	0.1	0.1	0.2	0.5
tal		130	100.0	100.0	100.0	100.0	100.0

Table 3.9 Uncompensated Care due to Private Patients
North Carolina Community Hospitals, FY82 ($000)

	Public	Non-Profit	For-Profit	Total
Charity	19,337	23,308	397	43,042
Bad Debt	27,092	101,094	3,645	131,831
Total Private Deductions from Gross Revenues	47,429	124,402	4,042	174,873
Adjusted to Operating Cost[1]	38,783	98,173	3,483	140,439
Offsets				
Hill-Burton Obligations[2]	3,733	11,613	202	15,548
Duke Endowment	283	951	--	1,234
Tax Appropriations[3]	21,766	1,229	28	23,023
Uncompensated Care	13,001	84,380	3,253	100,634
Total Expenses	449,941	1,399,568	123,058	1,972,567
% Uncompensated Care	2.9	6.0	2.6	5.1

[1] x (Total Expenses - Other Operating Revenue) / Gross Revenue

[2] Estimated at 10% of Total Obligations

[3] Assumes all reported tax appropriations are for indigent care
Excludes debt service by counties on general obligation bonds and associated tax expenditures. Excludes appropriations for AHEC.

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ESTIMATED PER CAPITA MEDICAL EXPENDITURES
FOR UNINSURED POOR PERSONS,
NORTH CAROLINA, 1984

TYPE OF CARE	SOURCES OF FUNDING	
	Paid by Patient	Paid By Others
HOSPITAL CARE	$ 35	$ 647
Publicly Funded Programs	--	152
Uncompensated Care*	--	495
ALL OTHER CARE	$ 123	$ 186
Publicly Funded Programs	--	186
Uncompensated Care	--	???
TOTAL	$ 158	$ 833

* Uncompensated care equals Bad Debts plus Charity, adjusted to costs and attributable to uninsured poor. Figure shown is based on actual 1982 costs, and projected to 1984 based on national trends in hospital input prices, intensity of care and utilization rates.

APPENDIX E - HEALTH EDUCATION AND PREVENTIVE HEALTH CARE - SUBCOMMITTEE MEMBERSHIP

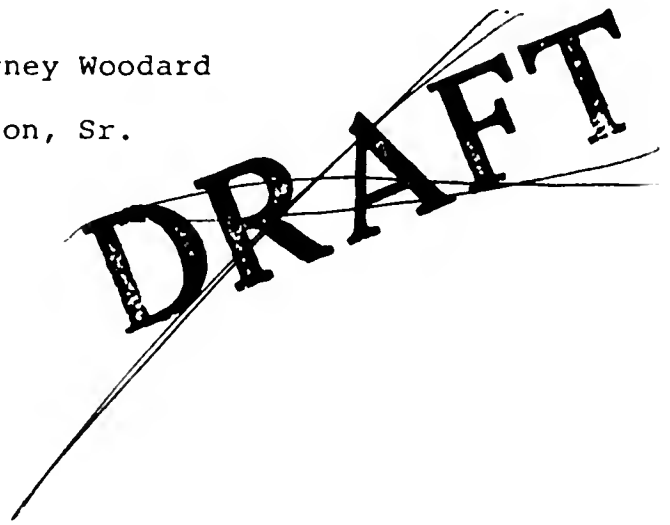
HEALTH EDUCATION AND PREVENTIVE HEALTH CARE
SUBCOMMITTEE

Mrs. Helen Goldston - Chairman

Mrs. Jimmie Butts

Representative Barney Woodard

Mr. Travis Tomlinson, Sr.



APPENDIX F - REPORT OF THE HEALTH EDUCATION AND PREVENTIVE - HEALTH SUBCOMMITTEE

Sub-Committee on Health Education
Medical Cost Containment Commission

ISSUE: The Health education needs of our State, and how it is related to health care cost containment.

HISTORY: The Sub-Committee on Health, Education and Prevention was established to look at issues which covers a broad scope of health related cost containment. The sub-committee has held two (2) meetings, and at its initial meeting committee members heard from interested persons who are involved in health education and planning. Committee members also got an opportunity to express their views on the issues. They also requested that the FRD staff have someone from DPI, who is knowledgeable on health education matters, speak before them at the next meeting.

During the last meeting of the committee, committee members heard presentation by FRD and DPI staff on the historical perspective of health education in North Carolina. The DPI speaker explained that in 1977, DPI formulated a long range health education program which included.

A. The employment of a health education coordinator in each of the local school units;
B. The establishment of a health education consultant position in DPI;
C. An allocation of monies for the development of a health education curriculum for grades K-12.

House Bill 540, enacted in 1978, authorized the appropriation of funds for employing a few health education coordinators, with the goal of one coordinator per local education agency. An additional position for a consultant on health education, the creation of a state-wide health education advisory council, and the development of a health curriculum (K-9) were also part of the legislation. In 1979 and 1984 funds were appropriated for an additional 24 health education coordinators. To date, a total of 32 coordinator positions have been funded statewide.

A Health Education Curriculum has been developed for grades K-12 and has been distributed to local school units. Also, a Health Education Advisory Council has been established.

SUB-COMMITTEE RECOMMENDATIONS:

1- The subcommittee recommends that the Medical Cost Containment Commission go on record as supporting the establishment of a health education coordinator position in all local school units.
2- The subcommittee recommends that the Health Education Curriculum be included as part of the Basic Education Plan.

APPENDIX G - HEALTH PLANNING AND CERTIFICATE OF NEED SUBCOMMITTEE MEMBERSHIP

SUBCOMMITTEE ON HEALTH PLANNING AND CERTIFICATE OF NEED

Mr. Carson Bain - Chairman

Dr. Sandra Greene

Mr. Travis Tomlinson, Sr.

Mr. Jack Willis

Dr. Lawrence Cutchins

Mrs. Jimmie Butts